STATE OF TENNESSEE
Certification of Health Care Provider
Family and Medical Leave Act of 1993

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category.

   (1)____ (2)____ (3)____ (4)____(5)____ (6)____ , or None of the above _____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different):

   b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below?) _____

   If yes, give the probable duration:

   c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity[2] :

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

   If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

   b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments.

   c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regime (e.g., prescription drugs, physical therapy requiring special equipment):

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[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

2 "**Incapacity**," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

7.a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? _____ If yes , please list the essential functions the employee is unable to perform:

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? _____

8.a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____

b. If no, would the employee's presence provide psychological comfort to be beneficial to the patient or assist in the patient's recovery? _____

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule

_____ _____
(Employee signature) (date)